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AUTHOR	Pulos, Victoria; Denker, Peggy
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ABSTRACT

Passed in 1997, the Children's Health Insurance Program (CHIP) was designed to expand and complement the Medicaid program, thereby reducing the number of U.S. children without health insurance. However, as states implemented welfare reform, many children and parents lost welfare benefits, and thereby Medicaid coverage. This study examined enrollment trends in CHIP and Medicaid from 1996 through 1999 in 12 states with the largest number of uninsured children to assess the early progress of CHIP and to understand the effects of welfare reform on the health coverage of low-income children. The states involved in the study were Arizona, California, Florida, Georgia, Illinois, Louisiana, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Texas. The states provided monthly enrollment data from January 1996 to June 1999, with data after CHIP's enactment categorized as regular Medicaid, expanded Medicaid under CHIP funding, or separate CHIP- funded state programs. The findings indicated that in 1999, fewer children were enrolled in federally funded children's health programs than were enrolled in Medicaid alone in 1996. Increases in CHIP enrollment have been offset by reductions in Medicaid coverage. Although CHIP got off to a slow start, enrollment is now growing rapidly and likely to continue growing. Further, CHIP is reaching children in families whose income levels previously made them ineligible for public coverage, and there is evidence that the program is helping to find children who were already eligible for Medicaid but were not enrolled. (KB)

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One Step Forward, One Step Back

Children's Health Coverage after CHIP and Welfare Reform

A REPORT BY

Families USA
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Washington, DC 20005
202-628-3030

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Families USA
1334 G Street, NW
Washington, DC 20005
Phone: (202) 628-3030
Fax: (202) 347-2417
E-mail: info@familiesusa.org
Website: www.familiesusa.org

INTRODUCTION

The passage of the Children's Health Insurance Program (CHIP) in 1997 reflected a bipartisan consensus that children in this country should have affordable health coverage. CHIP was designed to expand and complement the Medicaid program, which already provided health coverage for 23 million of the poorest children. By building on this existing foundation, the architects of CHIP hoped to significantly reduce the number of children in the United States who had no health insurance by making from three to five million more children eligible for coverage.[1]

Around the same time, the Medicaid program's coverage of poor families with children was undermined by implementation of welfare reform. Historically, welfare had been closely tied to Medicaid: Families who qualified for welfare automatically received Medicaid as well. The 1996 welfare reform law severed this tie, instead requiring that low-income families with children be covered irrespective of their eligibility for welfare benefits. However, as the states implemented welfare reform, many children and parents lost welfare benefits—and, in the process, lost Medicaid coverage.[2]

In order to assess the early progress of CHIP and to understand the effects of welfare reform on the health coverage of low-income children, Families USA collected data on 1996–1999 enrollment in these programs from the 12 states with the largest number of uninsured children. Those states are: Arizona, California, Florida, Georgia, Illinois, Louisiana, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Texas. Taken together, these 12 states account for almost two-thirds of the uninsured children in the United States. (See Appendix, Table 4.)

These state enrollment numbers paint a disturbing picture. In 1999, two years after the passage of CHIP and three years after passage of national welfare reform, fewer children in these states are enrolled in federally funded children's health programs than were enrolled in Medicaid alone in 1996. (See Table 1.) CHIP enrollment is increasing significantly, but these gains have been offset by reductions in children's Medicaid coverage—largely due to welfare reform. Recently

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released Census data for 1998 confirm that, nationwide, there has been no reduction in the number of children without health insurance coverage. The number of poor children declined in 1998, but the number of poor children without health insurance did not.

Despite this net reduction in children covered by federal-state health programs, there are some encouraging developments. CHIP is reaching uninsured children in lower-income families whose income levels previously made them ineligible for public coverage. Although CHIP got off to a slow start, enrollment is now growing at a rapid pace and is likely to continue growing. Furthermore, there are promising signs that CHIP is also helping to find children who were already eligible for Medicaid but were not enrolled.

Nonetheless, Medicaid and CHIP programs face a challenge if they are to succeed in reducing the number of children without health insurance. In addition to the challenges inherent in setting up new state programs and enrolling children through those initiatives, states must find ways to turn around recent declines in children's Medicaid coverage. Success in reducing the number of uninsured children in the years to come will require not only reaching out to the 11.1 million children who are now uninsured, but retaining coverage for the millions of children currently insured by Medicaid as well.

KEY FINDINGS

- In the 12 states with the largest number of uninsured children, children's enrollment in federal-state health programs (Medicaid and CHIP) declined from 11,166,178 in 1996 to 10,946,268 in 1999, a drop of 219,910, or 2.0 percent. (See Table 1.)

- In these 12 states, children's enrollment in Medicaid declined by nearly a million children (975,038) from 1996 to 1999. There were 11,000,510 children enrolled in Medicaid in these 12 states in 1996, but only 10,025,472 in 1999. This is an 8.9 percent decline in Medicaid coverage for children.

- In these 12 states, nearly a million children (920,796) were added to the Medicaid rolls or enrolled in separate state insurance programs by 1999 as a result of CHIP. (165,668 children were already covered by state-only programs in New York and Pennsylvania in 1996, so only 755,128 of these children represent new enrollment since 1996.)

- In five of the 12 states studied, there was a net *decline* in the number of children covered by Medicaid and CHIP from 1996 to 1999. Those states are: Arizona, California, Ohio, Pennsylvania, and Texas.

- In the remaining seven states, there was a net *increase* from 1996 to 1999. Those states are: Florida, Georgia, Illinois, Louisiana, New Jersey, New York, and North Carolina.

- The three states with the *greatest numerical drop* from 1996 to 1999 are: Texas (-193,400), California (-121,788), and Ohio (-40,475).

- The three states with the *greatest percentage drop* are: Texas (-14.2 percent), Ohio (-7.3 percent), and Arizona (-6.5 percent).

- The three states with the *greatest numerical increase* are: North Carolina (+78,796), New York (+50,755), and Louisiana (+35,466).

- The three states with the *greatest percentage increase* are: North Carolina (+15.8 percent), Louisiana (+8.4 percent), and New York (+3.2 percent).

- The 12 states were slow to start implementing CHIP, but recently, enrollment has grown significantly. There were no children enrolled in CHIP in December of 1997. By June 1998, there were 333,498 children enrolled, but that figure includes 175,005 children converted into CHIP from New York's pre-existing state program; only 158,493 *new* children were enrolled. By the end of 1998, enrollment had grown to 593,868, including 54,789 children converted into CHIP from Pennsylvania's pre-existing state program. By June of 1999, total CHIP enrollment in the 12 states had reached nearly one million children (920,796). (See Table 2.)

Table 1
Children's Enrollment in Medicaid and CHIP, 1996-1999

	1996[a]			1999[a]			Change	
	Medicaid	State Programs	Total Medicaid & State Programs	Medicaid	CHIP	Total Medicaid & Chip	Change 96-99	% Change 96-99
AZ	313,335		313,335	279,372	13,440	292,812	-20,523	-6.5%
CA	2,920,831		2,920,831	2,652,065	146,978	2,799,043	-121,788	-4.2%
FL	891,816		891,816	791,289	101,080	892,369	553	0.1%
GA	622,336		622,336	598,444	31,085	629,529	7,193	1.2%
IL	792,282		792,282	760,426	35,990	796,416	4,134	0.5%
LA	421,956		421,956	439,794	17,628	457,422	35,466	8.4%
NJ	379,164		379,164	356,730	32,495	389,225	10,061	2.7%
NY	1,495,611	115,000	1,610,611	1,309,093	352,273	1,661,366	50,755	3.2%
NC	500,277		500,277	535,299	43,774	579,073	78,796	15.8%
OH	556502		556,502	477,607	38,420	516,027	-40,475	-7.3%
PA	746,096	50,668	796,764	693,002	73,080	766,082	-30,682	-3.9%
TX	1,360,304		1,360,304	1,132,351	34,553	1,166,904	-193,400	-14.2%
12-state Total	11,000,510	165,668	11,166,178	10,025,472	920,796	10,946,268	-219,910	-2.0%

Notes: Based on comparison of one month's enrollment in each year. Medicaid enrollment is April of each year except FL (March), NC (June), and GA (March 1999). CHIP enrollment is as of June 1999. (See Methodology in Appendix for more information.)

Large numbers of children in NY and PA were converted from pre-existing state programs into CHIP on a one-time-only basis. Since these children are included in the 1999 CHIP totals for these two states, we include children enrolled in these state programs in 1996 so the table does not overstate growth in CHIP enrollment.

1996 monthly values were imputed for IL, OH, and LA based on total 1996 enrollment. (see Methodology).

In 1999, children covered by Medicaid expansions funded under CHIP are shown in the CHIP column, not in Medicaid.

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Figure 1
Change in Children's Enrollment in Medicaid and CHIP for 12 States, 1996-1999

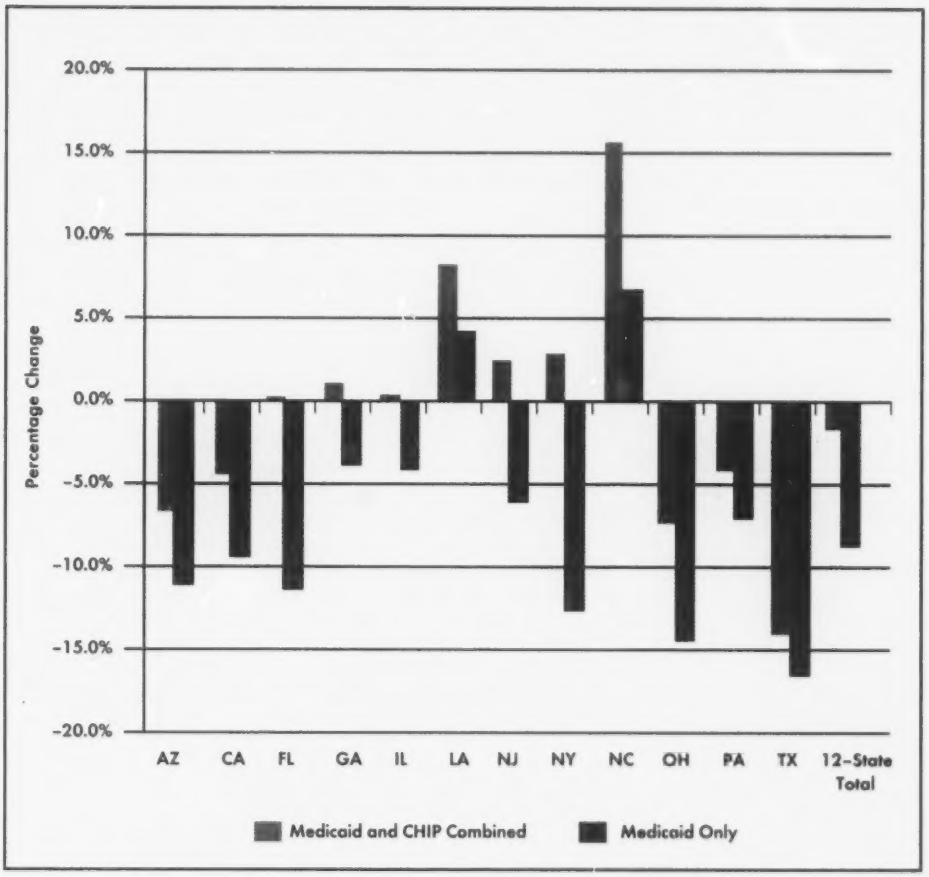

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Table 2

Monthly CHIP Enrollment, Effective Date to June 1999

Date	AZ (150%)*	CA (200%)	FL (200%)	GA (200%)	IL (185%)	LA (133%)	NJ (200%)	NY (230%)	NC (200%)	OH (150%)	PA (200%)	TX (100%)	12-State Total
Oct-97								149,314			50,864		
Nov-97								153,851			52,324		
Dec-97								159,117			52,592		
Jan-98					13,447			164,432		2,579	52,916		233,374
Feb-98					14,731			170,144		7,966	52,747		245,588
Mar-98		3,244			15,949		911	175,005		12,786	52,950		260,845
Apr-98		4,763	4,072		16,432		2,476	182,877		16,133	53,777		280,530
May-98		5,780	10,390		17,532		3,666	192,238		18,774	54,080		302,460
Jun-98		6,748	25,291		18,368		4,843	202,239		21,220	54,789		333,498
Jul-98		11,869	35,041		19,302		6,857	212,862		23,654	57,922	9,712	377,219
Aug-98		18,591	41,423		20,044		9,620	230,205		25,505	57,839	17,946	421,173
Sep-98		29,221	45,653		20,953		12,085	238,446		27,246	62,276	24,900	460,780
Oct-98		42,221	48,567		22,502		14,679	249,257	5,981	29,479	62,764	29,988	505,438
Nov-98	2,247	53,840	52,591	104	23,843	1,668	17,065	260,770	11,663	31,140	63,108	33,263	551,302
Dec-98	3,705	64,865	56,265	213	25,000	3,741	19,022	270,683	17,887	32,783	64,227	35,477	593,868
Jan-99	5,277	75,381	60,494	878	26,717	6,245	21,153	281,264	22,184	33,217	65,803	37,032	635,645
Feb-99	8,149	87,907	64,575	3,970	28,013	8,179	23,465	291,703	26,836	34,025	66,763	36,643	680,228
Mar-99	10,578	104,474	69,821	8,619	29,848	10,663	25,443	301,391	32,039	35,381	68,235	36,713	733,205
Apr-99	11,458	117,182	81,165	13,284	32,264	12,970	27,451	315,453	36,014	36,424	69,122	36,144	788,931
May-99	12,765	130,864	90,237	16,833	33,535	15,029	30,232	332,348	39,900	37,202	71,099	35,641	845,685
Jun-99	13,440	146,978	101,080	31,085	35,990	17,628	32,495	352,273	43,774	38,420	73,080	34,553	920,796

Notes: Shaded area in NY and PA reflect enrollment in Child Health Plus and PA CHIP prior to federal funding of these programs in each state. NY and PA converted all children into CHIP.
FL has converted its enrollment in Florida Healthy Kids into federally-funded CHIP on a case-by-case basis.

*State's CHIP expansion as percentage of federal poverty level

How Do Children's Health Coverage and Medicaid Declines Relate to the Overall Improvement in the Economy?

Despite a decrease in the child poverty rate between 1996 and 1998[3] and other signs of economic growth, neither the number nor percentage of children without insurance has improved during this period.[4] In 1996, 10.6 million children (14.8 percent of all children) lacked insurance. In 1998, 11.1 million children (15.4 percent of all children) lacked insurance. Although the number of children in poverty declined, the number of poor children without health insurance did not.[5] While employer-based coverage of poor children increased somewhat, this increase was more than offset by significant decreases in Medicaid coverage.[6]

Recent studies that take a closer look at the very poor have concluded that their situation has actually gotten worse. Among children living in single-mother families, there was a 26 percent increase in those living in extreme poverty (below 50 percent of poverty) between 1996 and 1997.[7]

How Do We Know that Many Children Leaving Medicaid Are Still Poor and Uninsured?

Although the economy is strong and more children now are covered by employer-based insurance, at least half the children who lose Medicaid when families move from welfare to work are likely to be uninsured. Most families moving from welfare to work still live below the poverty level; three-fourths are not offered insurance by their employers. With family earnings below the poverty level, the children in these families are eligible for regular Medicaid rather than CHIP.

A recent national survey by the Urban Institute provides the most comprehensive information available to date about what has happened to the parents and children who left welfare and did not return to the welfare rolls.

- Of those who left welfare because they got a job, fewer than one-fourth have employer-sponsored health insurance coverage;[8] it is not clear how many of them have access to dependent coverage for their families.
- The median income of families who left welfare for work was roughly equal to the poverty level for a family of three in 1997, so more than half of the children were probably eligible for Medicaid and most of the rest were probably eligible for CHIP.

Many uninsured children in families that move from welfare to work are still eligible for regular Medicaid because family earnings are low. State studies of families leaving welfare have also found that, although many families leave welfare for work,[9] they typically earn less than the poverty level,[10] well under Medicaid eligibility levels for children in most states.

A recent report by Families USA estimated the number of families that lose coverage due to welfare reform rather than to economic conditions or other causes. This study found that, as of 1997, nearly 700,000 people had become uninsured as a result of welfare reform, and 62 percent of them were children.[11] More than half of the children who would have been enrolled in Medicaid in 1997 absent welfare reform were instead uninsured.[12]

METHODOLOGY

Families USA collected data on enrollment in Medicaid and CHIP from 12 states. We did not use data submitted by states to the Health Care Financing Administration (HCFA) because there is a time lag of at least a year in the availability of Medicaid numbers and new CHIP reporting forms have not yet been released.

We chose the 12 states in the study because they were the states with the largest number of uninsured children. We asked each of these states to provide monthly enrollment data for children for the period from January 1996 to June

1999. We asked that enrollment data from the period after CHIP's enactment be broken down by the following categories: Medicaid at pre-CHIP eligibility levels ("regular Medicaid"), expanded Medicaid under CHIP funding (M-CHIP), and separate state programs funded by CHIP (S-CHIP). We compared year-to-year changes by looking at one month's Medicaid enrollment in 1996 with a similar month's combined enrollment in 1999.

States do not have common practices for recording enrollment data, nor do they have common reporting periods. Also, many states reported Medicaid and CHIP data in different sources. These differences are discussed in detail in the Appendix.

BACKGROUND

In 1998, there were 11.1 million children under the age of 18 who did not have health insurance.[13] One recent analysis estimated that 40 percent of all uninsured children were eligible for Medicaid but were not enrolled in the program, and another 35 percent would be eligible for coverage under CHIP if all states expanded eligibility to children in families with incomes up to 200 percent of the federal poverty level (that is, up to $27,760 for a family of three in 1999). The remaining 25 percent of uninsured children live in families with incomes above 200 percent of the federal poverty level.[14] This means that Medicaid and CHIP together have the potential to cover at least three-fourths of the country's uninsured children.

Medicaid

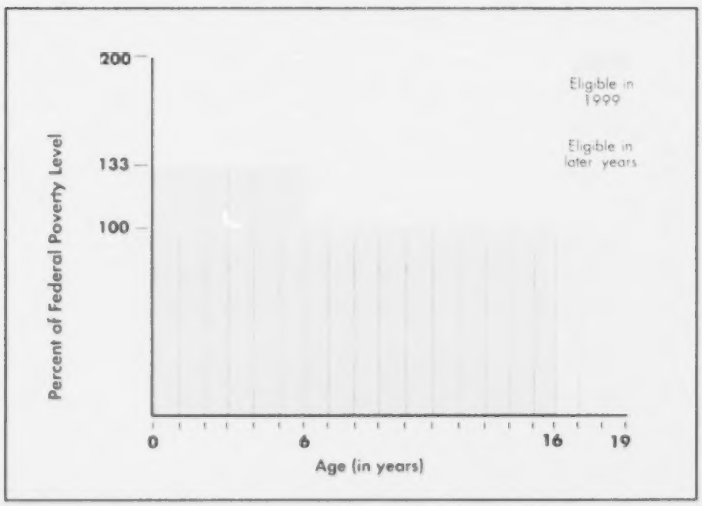
Established in 1965, the Medicaid program has been and remains the primary source of health insurance for low-income children. As of 1996, the beginning of our study, there were 23 million children under the age of 21 enrolled in Medicaid.[15] Many of these children were enrolled in Medicaid because their families qualified for cash welfare assistance.

Beginning in the 1980s, Congress moved to expand eligibility for Medicaid to children regardless of whether their families received cash welfare. States were required to phase in these expansions in Medicaid eligibility by 2002. (See Figure

2.) In addition, Congress gave states options to go further. For example, states could accelerate the schedule for covering older children with family income below poverty, and they could cover pregnant women and infants in families with incomes up to 185 percent of the poverty level. Many states elected to exercise such options. (See Map 1 for state Medicaid eligibility levels before enactment of CHIP.) As a result of these eligibility expansions, the number of children potentially eligible for Medicaid has been steadily increasing for at least a decade.

Figure 2

Mandatory Medicaid Eligibility Levels, October 1, 1999



Note: Medicaid requires coverage of children from birth to their 6th birthday if their family income is 133 percent of the federal poverty level or less, and children from their 6th birthday to their 19th birthday if they were born after October 1, 1983 and if their family income is 100 percent of the federal poverty level or less. By 2002, all poor children under the age of 19 will be covered. Children under 19 who were born before October 1, 1983 may be eligible on the basis of 1996 AFDC standards, which vary from state to state.

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CHIP

Congress passed the Children's Health Insurance Program (CHIP) in August 1997 in response to concern about the large number of children without health insurance.[16] CHIP is a cooperative federal-state program that provides health coverage to children who live in families with incomes above the Medicaid levels in effect in 1997 but under 200 percent of the federal poverty level.[17] As in the existing Medicaid program, the federal government matches state spending. To encourage states to take advantage of CHIP to cover more uninsured children, Congress specified that the federal government would provide an "enhanced match"; that is, it would pay a greater share of the costs for CHIP-funded expansions than it pays for a state's existing Medicaid program.

The new CHIP law encouraged states to increase coverage of uninsured children by:

- raising the income limits of the Medicaid program so more children could qualify (M-CHIP),
- creating a new insurance program separate from Medicaid (S-CHIP), or
- doing both.

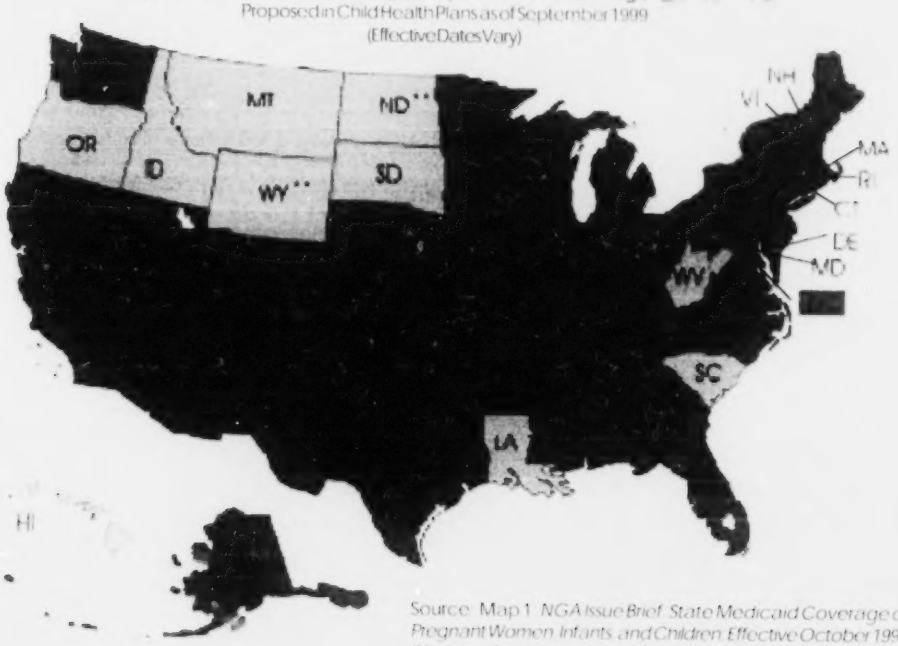
(In this report, the term "CHIP" refers to both kinds of expansion, "M-CHIP" refers to Medicaid expansions with CHIP funding, "S-CHIP" refers to separate or standalone insurance programs funded by CHIP, and "regular Medicaid" refers to Medicaid coverage at family income levels that would have qualified children for coverage before the CHIP expansions.)

In addition to expanding eligibility, CHIP directed states to develop outreach plans for children eligible for CHIP or other health coverage programs like Medicaid and to coordinate with Medicaid (and any other health coverage programs available in the state).[18] Furthermore, CHIP-funded programs are specifically required to screen applicants for Medicaid eligibility at income levels in effect before any CHIP-funded expansion and to enroll eligible children in regular Medicaid.[19]

Map 1. Pre-CHIP Medicaid Eligibility for Children Age ≥6 to <18

Map 2. Medicaid-CHIP Eligibility for Children Age ≥6 to <18

Proposed in Child Health Plans as of September 1999
(Effective Dates Vary)



Source: Map 1: *NGA Issue Brief: State Medicaid Coverage of Pregnant Women, Infants, and Children Effective October 1997* (National Governor's Association, Washington, DC, September 1997)

Map 2: Families USA analysis of Child Health Plans

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Welfare Reform

When national welfare reform was enacted in 1996, Congress recognized that there has been a long-standing relationship between cash welfare and Medicaid. Because receipt of cash welfare was the most common path to Medicaid, efforts to cut people off welfare or discourage them from applying could have become barriers to enrollment in Medicaid. Despite efforts by Congress to prevent this outcome, the recent dramatic drop in the welfare rolls has been accompanied by a decline in the number of people enrolled in Medicaid. By 1997, the earliest days of welfare reform, nearly 700,000 low-income people had lost Medicaid coverage and became uninsured due to welfare reform. The majority (62 percent) were children.[20]

There are three ways children lose health coverage as a result of welfare reform. First, children lose coverage when their families successfully move from welfare to work and family earnings exceed Medicaid eligibility levels, but employers do not offer affordable family coverage. Second, termination of welfare for any reason often results in wrongful losses of Medicaid coverage. Most children in families losing cash welfare, including families in which parents go to work, are probably still eligible for Medicaid, but a significant number of them have been cut from the program. Third, state efforts to deter families from applying for welfare can result in people being denied the opportunity to apply for Medicaid for their children.[21] Expanding coverage to children in lower-income families through CHIP addresses the problem of families who earn too much for regular Medicaid, but states must do more to address the remaining causes of Medicaid declines.

The Effects of Welfare Reform's Immigrant Eligibility Restrictions on Citizen Children

While almost nine out of ten uninsured children who are eligible for Medicaid were born in the U.S., over one-third live with at least one parent who was born in a foreign country.[22] As U.S. citizens, U.S.-born children are eligible for Medicaid and CHIP, but many families fear adverse consequences for non-citizen family members if citizen children enroll in Medicaid and CHIP. This fear is based in part on provisions of the welfare reform law that impose new restrictions on the ability of some legal immigrants to benefit from public programs like Medicaid and CHIP. Although these restrictions were not intended to affect citizen children, a study of Medi-Cal applications in Los Angeles County found that the number of newly approved citizen children who had non-citizen parents dropped by 48 percent between January 1996 and 1998, whereas there was almost no change for citizen children of citizen parents. Nationwide, 21 percent of all uninsured children live in families with mixed citizenship status. In states with large immigrant populations, the numbers are even more striking. Over one-half of California's uninsured children, for example, live in such mixed families.[23]

FINDINGS

In the 12 states with the largest number of uninsured children, there were 11,166,178 children covered by the Medicaid program and two state-funded programs in 1996 and 10,946,268 covered by Medicaid and CHIP in 1999. This is a net decline of 219,910, or 2.0 percent. (See Table 1.)

Arizona

- Arizona had 313,335 children enrolled in Medicaid in 1996. In 1999, Arizona had 279,372 children enrolled in Medicaid—a decline of 33,963. Arizona enrolled 13,440 children in expansions funded by CHIP. Overall, this resulted in a decline of 6.5 percent, or 20,523 children, from 1996 to 1999.

- Enrollment in Arizona's S-CHIP program, KidsCare, grew from 5,277 children in January 1999 (its third month of operation) to 13,440 in June 1999 (its eighth month of operation). Enrollment should continue to grow, especially since the eligibility level was raised from 150 to 200 percent of the federal poverty level as of October 1, 1999.

California

- California had 2,920,831 children enrolled in Medicaid in 1996. In 1999, California had 2,652,065 children enrolled in Medicaid—a decline of 268,766. California enrolled 146,978 children in expansions funded by CHIP. Overall, this resulted in a decline of 4.2 percent, or 121,788 children, from 1996 to 1999.

- Enrollment in California's S-CHIP and M-CHIP programs (Healthy Families and Medicaid for Teens, respectively) almost doubled from 75,381 children in January 1999 to 146,978 in June 1999. The Healthy Families eligibility level will soon be raised from 200 to 250 percent of poverty.

- California's sizable Medicaid drop-off largely ceased in 1998 when counties established a temporary moratorium on Medicaid terminations for families losing cash welfare until new computer programming was in place. Almost 240,000 children may be at risk of losing benefits when counties resume eligibility redeterminations in 1999.[24]

Florida

- Florida had 891,816 children enrolled in Medicaid in 1996. In 1999, Florida had 791,289 children enrolled in Medicaid—a decline of 100,527. Florida enrolled 101,080 children in expansions funded by CHIP. Losses in Medicaid and gains in CHIP enrollment essentially offset one another from 1996 to 1999.

- Enrollment in Florida's four programs created or expanded with CHIP funding grew by more than two-thirds in the latest five-month period, from 60,494 children in January 1999 to 101,080 in June 1999. (About 53,000 children

were enrolled in Florida's Healthy Kids program before CHIP legislation passed. These children are being converted from Healthy Kids into CHIP on a case-by-case basis, but by July 1999, only about half had been converted.)

- As of July 1999, 19,000 uninsured children were on a waiting list for the Florida Healthy Kids program due to inadequate funding.
- In August 1999, a class action lawsuit was filed against the State of Florida, claiming that families that lose cash welfare were illegally dropped from Medicaid.[25] In September 1999, the state changed its Medicaid policies related to "de-linking" welfare and Medicaid.

Georgia

- Georgia had 622,336 children enrolled in Medicaid in 1996. In 1999, Georgia had 598,444 children enrolled in Medicaid—a decline of 23,892. Georgia enrolled 31,085 children in expansions funded by CHIP. This is an overall increase of 1.2 percent, or 7,193 children, from 1996 to 1999.
- Enrollment in Georgia's S-CHIP program, PeachCare, grew from 878 children in January 1999 (the first month of its statewide operation) to 31,085 in June 1999.

Illinois

- Illinois had 792,282 children enrolled in Medicaid in 1996. In 1999, Illinois had 760,426 children enrolled in Medicaid—a decline of 31,856. Illinois enrolled 35,990 children in expansions funded by CHIP. This is an overall increase of 0.5 percent, or 4,134 children, from 1996 to 1999.
- Enrollment in the Illinois CHIP program, KidCare, grew from 26,717 children in January 1999 to 35,990 in June 1999. One-third of the children in Illinois KidCare were enrolled through a one-time search of Medicaid computer records to find children who had been turned down for Medicaid because family income was too high.[26]

Louisiana

- Louisiana had 421,956 children enrolled in Medicaid in 1996. In 1999, Louisiana had 439,794 children enrolled in Medicaid—an increase of 17,838. Additionally, Louisiana enrolled 17,628 children in expansions funded by CHIP. This is an overall increase of 8.4 percent, or 35,466 children, from 1996 to 1999.

- Enrollment in Louisiana's CHIP program, LaCHIP, grew almost three-fold from 6,245 children in January 1999 to 17,628 in June 1999. Enrollment should continue to grow, especially since the eligibility level was raised from 133 to 150 percent of the federal poverty level on October 1, 1999.

- Louisiana has 142,300 uninsured children who are eligible for regular Medicaid but not enrolled, compared to 52,000 children newly eligible for M-CHIP at the expanded income eligibility limit of 150 percent of poverty.

New Jersey

- New Jersey had 379,164 children enrolled in Medicaid in 1996. In 1999, New Jersey had 356,730 children enrolled in Medicaid—a decline of 22,434. New Jersey enrolled 32,495 children in expansions funded by CHIP. This is an overall increase of 2.7 percent, or 10,061 children, from 1996 to 1999.

- Enrollment in New Jersey's CHIP program, NJ KidCare, grew from 21,153 children in January 1999 to 32,495 in June 1999. The eligibility level was raised to 350 percent of poverty through income "disregards" (see endnote 17) on August 1, 1999.

New York

- New York had 1,495,611 children enrolled in Medicaid in 1996. In 1999, New York had 1,309,093 children enrolled in Medicaid—a decline of 186,518. In 1996, there were 115,000 children enrolled in New York's state-funded insurance program. By 1999, 352,273 children were enrolled in expansions funded by CHIP. This is an overall increase of 3.2 percent, or 50,755 children, from 1996 to 1999.

- New York had a large children's health insurance program, Child Health Plus, in place prior to CHIP's enactment. When CHIP took effect in New York in April 1998, all 175,005 children then in Child Health Plus were converted into New York's S-CHIP program. Then, with this head start, enrollment in S-CHIP grew to 281,264 children in January 1999 and reached 352,273 in June 1999; however, it is estimated that over 40 percent of children enrolled in Child Health Plus are probably eligible for Medicaid.[27]

- In January 1999 a federal judge ruled that, under welfare reform, New York City had improperly prevented families from applying for Medicaid benefits.[28]

North Carolina

- North Carolina had 500,277 children enrolled in Medicaid in 1996. In 1999, North Carolina had 535,299 children enrolled in Medicaid—an increase of 35,022. Additionally, North Carolina enrolled 43,774 children in expansions funded by CHIP. This is an overall increase of 15.8 percent, or 78,796 children, from 1996 to 1999.

- Enrollment in North Carolina's S-CHIP program, Health Choice for Children, doubled from 22,184 children in January 1999 to 43,774 in June 1999.

Ohio

- Ohio had 556,502 children enrolled in Medicaid in 1996. In 1999, Ohio had 477,607 children enrolled in Medicaid—a decline of 78,895. Ohio enrolled 38,420 children in expansions funded by CHIP. This is an overall decline of 7.3 percent, or 40,475 children, from 1996 to 1999.

- Enrollment among uninsured children eligible for Ohio's M-CHIP program grew from 33,217 children in January 1999 to 38,420 in June 1999. In addition to its M-CHIP program, Ohio raised the Medicaid eligibility level for children who are ineligible for CHIP but have inadequate insurance. It will further raise the eligibility level from the current 150 percent to 200 percent of poverty in January 2000.

Pennsylvania

- Pennsylvania had 746,096 children enrolled in Medicaid in 1996. In 1999, Pennsylvania had 693,002 children enrolled in Medicaid—a decline of 53,094. In 1996, there were 50,668 children enrolled in Pennsylvania's state-funded insurance program. By 1999, 73,080 children were enrolled in expansions funded by CHIP. This is an overall decrease of 3.9 percent, or 30,682 children, from 1996 to 1999.

- Pennsylvania, like New York, had a significant children's health insurance program in effect before CHIP was enacted and those children were rolled over in CHIP. The children enrolled in the Pennsylvania program, PACHIP, were converted to CHIP in July 1998. Enrollment in CHIP was 65,803 in January 1999 and reached 73,080 in June 1999.

- In July 1999, after negotiations with legal services and child advocacy groups, the Pennsylvania Department of Public Welfare announced it would address Medicaid declines related to welfare reform through a series of steps, including reinstatement for 24,000 children who had wrongfully lost Medicaid.

Texas

- Texas had 1,360,304 children enrolled in Medicaid in 1996. In 1999, Texas had 1,132,351 children enrolled in Medicaid—a decline of 227,953. Texas enrolled 34,553 children in expansions funded by CHIP. This is an overall decline of 14.2 percent, or 193,400 children, from 1996 to 1999.

- Texas expanded Medicaid to 100 percent of poverty for older teens; this expansion was already required by federal law, but Texas made the change sooner than required. Enrollment in this expansion fell from 37,032 in January 1999 to 34,553 in June 1999. In 1999, at the first legislative session since the enactment of CHIP, the Texas legislature approved a CHIP expansion to 200 percent of poverty. This expansion will take effect in the year 2000 and make an additional 470,000 children eligible for coverage.

DISCUSSION

This report looks at the status of public programs providing health insurance coverage for children, which have recently been buffeted by two conflicting forces. On the one hand, hundreds of thousands of poor children lost Medicaid coverage and became uninsured in the wake of welfare reform. On the other hand, enactment of CHIP marked a new effort to insure children who were never before eligible for public coverage. In part, these forces reflect a new emphasis on support systems for the working poor.

A decade before passage of CHIP, Congress took the first steps in this shift by expanding Medicaid eligibility to children whose families do not qualify for cash welfare. Few states accompanied these expansions with any sustained effort to inform working families about the new coverage available for their children; nor did all states re-tool the Medicaid application process to make it convenient for working families. Not surprisingly, an estimated 4.7 million uninsured children eligible for coverage under these Medicaid expansions were not enrolled.[29]

When the national welfare reform law extended Medicaid eligibility to very poor families, whether they received cash welfare or not, the changes needed to make this welfare-Medicaid "de-linking" work were similarly neglected. As a result, thousands of children improperly lost Medicaid coverage. Children who once received Medicaid as an adjunct of cash welfare often remain eligible for Medicaid when their parents move from welfare to low-paying entry level jobs. Yet, as a report by Families USA showed, over half of the children who lost Medicaid due to welfare reform are uninsured.[30]

In 1997 a new dynamic came into play with passage of CHIP. Unlike earlier Medicaid expansions, CHIP was designed to make the states more accountable for achieving the goal of the legislation—reducing the number of uninsured children. For these and other reasons, the passage of CHIP generated far more public interest than earlier expansions. The states, with leadership from the federal government and in partnership with many community groups, began a concerted effort to identify barriers to enrollment for working families and to aggressively market the availability of children's health coverage. Some states have accepted the challenge of reducing the number of uninsured children and recognized the need to find and enroll the millions of uninsured children eligible for Medicaid.

However, because the federal government pays a larger share of the costs of CHIP, there is a greater financial incentive for states to increase enrollment in CHIP than to enroll the poorest children in Medicaid. These broad themes play out differently in each of the states. The cases of New York and California are illustrative.

A CLOSER LOOK:
Why Medicaid Enrollment Went Down and CHIP Went Up: I

In New York, there were 186,518 fewer children enrolled in Medicaid in April 1999 than in April 1996, but 237,273 more children enrolled in the state's S-CHIP program, Child Health Plus, in1999 than in 1996. What happened?

New York's cash welfare rolls declined by almost one-third between 1996 and 1999.[31] A study of former welfare recipients in New York City found that, of respondents working at the time of the survey (about six months after they left welfare), 46 percent were uninsured and only 14 percent were receiving Medicaid. Of those who were uninsured, all were eligible for a program to continue Medicaid for families moving from welfare to work (Transitional Medicaid), but none had received it.[32]

Under welfare reform, New York City had converted some of its welfare offices to job centers. A class action lawsuit charged that these job centers were illegally discouraging families from applying for Medicaid (and food stamps); in 1999, a federal judge ordered the city to change its practices.[33] Focus groups of low-income families in New York City identify many other barriers to Medicaid, from inconvenient office hours and burdensome paperwork requirements to demeaning treatment by welfare workers.[34] Also, by June 1999, New York had not yet undertaken any application simplification or other enrollment reforms in its children's Medicaid program as part of implementing CHIP. Families applying for Medicaid for their children must still fill out lengthy application forms and appear for interviews at local welfare offices.

In contrast to the difficulties facing applicants for Medicaid in New York, applicants for its S-CHIP program, Child Health Plus, can complete a short ap-

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plication form and return it by mail to a participating health plan. To its credit, New York had created a health insurance program for children ineligible for Medicaid many years before passage of CHIP. New York already had approximately 175,000 children enrolled in Child Health Plus in March 1998, the month before the state's CHIP plan was approved. All of the children in Child Health Plus were converted to CHIP in April 1998, giving the state a head start in enrollment. In Child Health Plus, the health plans—rather than a state agency or a third-party administrator—make eligibility determinations and screen children for Medicaid eligibility. A 1998 audit of the Child Health Plus program concluded that over 40 percent of the children enrolled by health plans appeared to be financially eligible for Medicaid.[35] Despite the federal requirement that children be screened for Medicaid eligibility and enrolled in Medicaid if eligible, the health plans in New York only refer families to Medicaid and, in the meantime, enroll them in Child Health Plus.[36] Other states have estimated that between one-fourth and one-half of children using new, simplified joint mail-in application forms are being enrolled in regular Medicaid rather than CHIP-funded programs. If 40 percent of the children who are enrolled in Child Health Plus are really eligible for Medicaid, New York's dramatic growth in enrollment is considerably less impressive than it appears.

However, both the federal and state government are starting to address the problem of Medicaid declines in New York, and there are reasons to expect improvement. The federal government has begun a review of barriers to Medicaid eligibility in New York City and in June 1999 extended it to the rest of the state.[37] In the spring of 2000, New York will begin to distribute up to $10 million to community-based organizations to conduct outreach initiatives and assist with applications. A simplified joint application form for Child Health Plus and Medicaid will be used, and the Medicaid face-to-face interview requirement will be satisfied by an interview at the community based organization. Another reform that should improve Medicaid enrollment is the adoption of 12-month continuous eligibility for children in Medicaid starting with children who apply or have applications renewed after January 1999. (See the discussion below for more on the continuous eligibility option.)

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A CLOSER LOOK:
Why Medicaid Enrollment Went Down and CHIP Went Up: II

California has the highest number of uninsured children in the country. The state's Medicaid program, known as Medi-Cal, covered 268,766 fewer children in April 1999 than in April 1996—a 9 percent drop. Its S-CHIP program, Healthy Families, began in July 1998. One year later, Healthy Families covered 133,273 children. (An additional 13,705 children were enrolled in California's M-CHIP program.)

A look at year-to-year changes in Medi-Cal children's enrollment (not including M-CHIP) reveals a dramatic development in 1998. Enrollment dropped by 113,920 children between 1996 and 1997 and by another 169,192 children between 1997 and 1998. From 1998 to 1999, however, enrollment dropped by only 4,122. What changed?

In January 1998, California's Medicaid agency placed a moratorium on dropping most families from Medicaid when they lost cash welfare; the moratorium was intended to give the state and counties time to develop policies and reprogram their computers to carry out changes made by the new welfare law. Although the moratorium was lifted at the end of the year, counties still face a large backlog in the number of families whose eligibility for Medicaid must now be redetermined: By mid-summer1999, the counties had processed fewer than 10 percent of the families awaiting redetermination.[38] Approximately 240,000 children are affected by the moratorium. What is likely to happen to these children?

Not only is the redetermination process facing a backlog, but a recent report also warned that it is dauntingly complex. This report concluded that state health forms require college-level reading skills and ask for more than four times as much information and supporting documentation as federal income tax forms.[39] Another study of children who lost cash welfare prior to the moratorium found that, three months later, only 20 percent had been transferred into other Medi-Cal non-cash categories.[40] If the underlying causes of this problem are not corrected, thousands of children now awaiting redetermination are at risk of losing coverage.

In Medi-Cal, eligibility must be renewed every three months and also when cash welfare ends or when other family circumstances change. By contrast, California's Healthy Families program guarantees eligibility for 12 months. In addition, California has made changes to increase enrollment in Healthy Families: The state simplified the joint mail-in application form and the application process, and also offered contracts to community based organizations so those organizations could find hard-to-reach children. Before these changes, average monthly new enrollment was 10,378 children. After the form change and contracts, new enrollment averaged 14,735 children per month. Later in 1999, California will raise eligibility for Healthy Families to 250 percent of net income (from 200 percent of gross income) and will use state-only funds to cover legal immigrant children who are ineligible for federal CHIP funds. Also on the positive side, California distributed over $17 million in federal matching funds to counties for the purpose of identifying families at risk of losing Medi-Cal due to welfare reform.

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Slow Start on CHIP Implementation

Most states operate on a fiscal year that runs from July 1 to June 30. By the time CHIP was signed into law in August 1997, state budgets had already been set and many state legislatures had adjourned. So, although the new program took effect on October 1, 1997, few states were in a position to take full advantage of CHIP. Several states quickly took modest steps to expand Medicaid, but developing a full-blown plan, persuading the legislature to allocate the necessary funds, and getting HCFA's approval for the state's proposal took more time. By the end of the first year that CHIP was in effect, only 33 states had programs up and running, and only 10 of those programs had been enrolling children for nine months or more. (See Table 3.)

A CLOSER LOOK:
Legislative Timetable Slows CHIP

Texas, which has the second highest number of uninsured children in the country, got a particularly slow start. Having adjourned before CHIP was enacted, the Texas legislature did not meet again until 1999. In the meantime, in July 1998, Texas implemented a modest expansion for older teens, covering those with family incomes up to 100 percent of poverty somewhat faster than already required by federal law. When the legislature met in 1999, it approved a further expansion of eligibility to 200 percent of poverty; this expansion will take effect in the year 2000.

Table 3

Status of CHIP Implementation in 50 States and the District of Columbia

Implementation Status as of	September 30, 1998 (end of Federal Fiscal Year 1998)	September 30, 1999 (end of Federal Fiscal Year 1999)
	No. of States	No. of States
No Plan Filed	2	0
Plan Filed but not Implemented	17	3
Implemented for 1 to 4 Months	14	0
Implemented for 5 to 8 Months	9	3
Implemented for 9 Months or More	10	45

Enrollment Starting to Grow

Despite this slow start, CHIP is now starting to take hold. All 50 states and the District of Columbia have now developed CHIP plans and have received HCFA's approval to implement them. All but three states are now enrolling children. By June 1999, there were 920,796 children enrolled in M-CHIP and S-CHIP programs in the 12 states in our study. This progress is likely to continue. Three states have plans that do not take effect until next year, and at least 12 states plan to expand their CHIP programs further after September 1999.

One clear result of CHIP is the broadening of eligibility. Prior to enactment of CHIP in 1997, Medicaid programs in 23 states and the District of Columbia did not even offer coverage to all children under the federal poverty level; in some of these states, coverage for older adolescents was limited to those whose family incomes were less than 20 percent of the poverty level. Only nine states provided coverage to children in families with incomes at or above 185 percent of poverty. (See Map 1.) All states now have Medicaid or CHIP programs that cover children with family incomes up to at least 100 percent of the federal poverty level.[41] By July 2000, 41 states will cover children with family incomes up to at least 185 percent of poverty. (See Map 2.) Nine of these 41 states will offer coverage to children with family incomes *over* 200 percent of the federal poverty level.[42]

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Outreach and Enrollment Reforms

Another positive contribution of CHIP is in the area of outreach and enrollment, which has long been a problem in Medicaid. State administration of Medicaid programs has frequently been marred by inadequate outreach and complex, daunting application processes. Recent research from surveys and focus groups shows widespread misunderstanding about Medicaid eligibility levels for children: Many people still assume that Medicaid is limited to nonworking, single-parent families that receive cash welfare.[43] In addition, families have identified many barriers in the application and eligibility-determination process, such as confusing application forms, burdensome documentation requirements, and inconvenient office hours.[44] As a result, millions of children who are eligible for Medicaid are not enrolled in the program.

There are some encouraging signs that states are learning from past mistakes they made in Medicaid and are now applying those lessons to Medicaid and to programs funded by CHIP. (See Table 5 in the Appendix.) For example, 11 of the 12 study states no longer look at whether families own cars or other assets in determining financial eligibility for children's Medicaid or CHIP. Ten of the 12 states permit applications to be filed by mail for both children's Medicaid and CHIP with no face-to-face interview at a local office required. (See Table 5.) In addition, the CHIP statute requires states to screen applicants for Medicaid eligibility at the income levels in effect before the state adopted any CHIP-funded expansion and to enroll eligible children in regular Medicaid. This "screen and enroll" requirement serves two purposes: It ensures appropriate coverage of the lowest-income children, and it prevents states from improperly enrolling these children in CHIP-funded expansion programs in order to claim the higher federal matching rate. (See box, "A Closer Look: Finding Children Eligible for Regular Medicaid.")

A CLOSER LOOK:
Finding Children Eligible for Regular Medicaid

It is estimated that 4.7 million uninsured children were eligible for Medicaid but not enrolled prior to enactment of CHIP.[45] In many states, the number of uninsured children eligible for regular Medicaid is far greater than the number of children eligible for coverage under new CHIP programs. Therefore, reducing the number of children without insurance will require finding and enrolling children eligible for regular Medicaid as well as enrolling children newly eligible for CHIP. Several states report that a significant number of children applying on new joint application forms or at new sites appear to be eligible for regular Medicaid.

- Arizona officials report that roughly half the children enrolled from new joint application forms go into Medicaid.[46]
- Since it started processing joint applications at a central site, California has referred about 25 percent of those submitting joint applications to its Medi-Cal program.[47]
- In Florida, over half the joint applications screened are referred to Medicaid.[48]
- In Georgia, about 24 percent of children applying with the new joint form are enrolled in Medicaid.[49]
- In Illinois, the central unit that processes joint mail-in applications and applications from outstation sites reports that approximately 80 percent of approved applications have been for regular Medicaid or M-CHIP rather than S-CHIP.[50]
- Monthly enrollment data in North Carolina show a striking increase in children's Medicaid enrollment since S-CHIP took effect. Prior to S-CHIP, monthly Medicaid enrollment ranged from 500,277 to 511,860 from June 1996 to September 1998. Since implementation of S-CHIP, monthly Medicaid enrollment has grown from 517,942 in October 1998 to 535,299 in June 1999.

More to Be Done to Keep Children Enrolled

Despite the number of states adopting reforms at the application and enrollment stage, fewer states are taking advantage of new options that could help them retain children enrolled in Medicaid. Taking steps to improve retention can help prevent children from wrongly losing Medicaid when the family loses cash welfare and when eligibility is periodically renewed. One of the retention options available to the states is to enroll children in Medicaid for a continuous 12-month period, regardless of changes in family income. This is important for families moving from welfare to work and for low-income families who often experience frequent fluctuations in family income that could otherwise disrupt coverage. Continuous eligibility also eliminates the procedural barrier of renewing eligibility at three- or six-month intervals. Few states have adopted a policy of 12-month continuous eligibility for children in Medicaid, but more states have that policy for S-CHIP programs.

A CLOSER LOOK:

Continuous Eligibility Helps Keep Children Enrolled

Ohio analyzed the children who dropped out of its M-CHIP categories at the six-month renewal point and found that it was losing over half of the children enrolled. Of these children, 54 percent were either over-income or had failed to reapply, and 46 percent had experienced a decline in income and converted to regular Medicaid.[51] In contrast, California, which has adopted 12-month eligibility in S-CHIP but not in Medicaid, had lost only 3 percent of children enrolled in S-CHIP during the first year of program operations.[52]

In addition to adopting 12-month continuous eligibility, there are a variety of other steps that should be taken to ensure that children enrolled in Medicaid or CHIP do not lose coverage. Current federal law requires that states take some of these steps, but not all states have implemented them. These steps include making

improvements in the state's computer system and educating welfare workers and families about the changes in welfare and Medicaid. (See box, "What Can States Do to Prevent Medicaid Declines Related to Welfare Reform?") As mentioned above, a recent lawsuit in Florida charges that many families are illegally losing Medicaid when cash welfare ends. Pennsylvania recently agreed to remedy unlawful Medicaid losses. In September 1999, Maryland and Washington also agreed to take steps to remedy unlawful Medicaid terminations for families losing welfare as a result of the state's failure to effectively "de-link" welfare and Medicaid.

What Can States Do to Prevent Medicaid Declines Related to Welfare Reform?

Finding and Enrolling Children

- Develop Medicaid-only application forms for regular Medicaid and M-CHIP and make them available at district or local offices as an alternative to long combined applications for welfare, food stamps, and Medicaid.
  - Keep forms simple; ask no more than needed to determine eligibility and gather basic demographic information.
  - Keep third-party documentation requirements to a minimum.
  - Inform families of the choice between the Medicaid-only form and a longer form covering more programs.
- In states that try to divert people from applying for welfare, process the Medicaid portion of a combined welfare-Medicaid application independently and make Medicaid-only applications available.
- Accept Medicaid applications by mail without requiring a face-to-face interview.
- Offer assistance filling out application forms and answering questions about Medicaid at convenient times and places. Offer:

- toll-free helplines staffed during convenient hours,
- outstationed eligibility sites with state workers who can make eligibility determinations and with community workers who can help with preliminary processing,
- convenient office hours at local or district offices (on at least some weekdays, open early or late, and always stay open over the lunch hour), and
- mini-grants to community groups for innovative application assistance initiatives.

- Provide application materials and assistance in Spanish and other languages spoken in the community.
- Adopt "presumptive eligibility" for children to provide Medicaid right away while the application is being processed.
- Offer education to the community about the wide availability of Medicaid and CHIP—even for two-parent working families.
- Enlist the help of community-based groups in providing outreach—particularly to immigrants, minorities, and other underserved populations.
- Monitor denial rates and revise procedures if a high percentage of Medicaid and CHIP applications are being denied for procedural reasons.

Retaining Children on Medicaid

- Adopt 12-month continuous eligibility for children.
- Simplify redetermination procedures.
- Make sure computer systems do not automatically terminate Medicaid when cash welfare is cut off.
- Before terminating Medicaid assistance, comply with legal

requirements to review all families losing cash welfare to see if they are eligible under other Medicaid categories, including:

- Transitional Medicaid for the entire family,
- children's Medicaid,
- M-CHIP (also review for eligibility under separate insurance programs, S-CHIP), and
- "medically needy" coverage for the entire family.

- Reprogram computers to do as much of the review as possible automatically.
- Update termination notices to clearly reflect current Medicaid policy.
- Require supervisory approval before authorizing any welfare-related Medicaid terminations until computer systems are working smoothly.
- Assure that if families are sanctioned under welfare work rules, children do not illegally lose Medicaid.
- Take advantage of options to offer families moving from welfare to work continued Medicaid coverage:
  - Extend the time for Transitional Medicaid.
  - Raise income thresholds by using liberal income disregards in regular Medicaid and M-CHIP.
  - Eliminate asset tests in Medicaid.
- Educate families, vocational service providers, and other contractors about the continued availability of Medicaid when families leave cash welfare.
- Design quality control pilot studies to test the effectiveness of state systems for retaining Medicaid when families lose cash welfare.

CONCLUSION

This country faces an enormous challenge: How can it ensure that all children have health insurance coverage so they can obtain needed care? Enactment of the CHIP program in 1997 constituted one important step forward in the effort to increase coverage. Unfortunately, states' implementation of federal welfare reform, which has resulted in thousands of children losing Medicaid coverage and becoming uninsured, has been a large step backward. The result is that, despite the demonstrable progress made by the CHIP program, fewer children are covered by Medicaid and CHIP today than were covered by Medicaid alone in 1996.

It will not be easy to reverse the damage done by welfare reform and put the nation back on track to expanded health coverage for children, but it must be done. Much of the burden will fall on state governments: They will have to take steps to prevent the wrongful loss of Medicaid for people who lose cash welfare, find ways to reach out to children who are eligible for Medicaid and make sure they are enrolled, and continue—and build upon—the progress made so far in implementing the new children's health initiatives authorized by the CHIP program.

ENDNOTES

[1] Thomas M. Selden, Jessica S. Banthin, and Joel W. Cohen, "Waiting in the Wings: Eligibility and Enrollment in the State Children's Health Insurance Program," *Health Affairs* 18, no. 2 (March/April 1999):126-133.

[2] Families USA, *Losing Health Insurance: The Unintended Consequences of Welfare Reform* (Washington, DC: Families USA, May 1999).

[3] In 1996, 14.5 million children—20.5 percent of all children—were living below the poverty line. In 1998, 13.5 million children—18.9 percent of all children—were living below the poverty line. U.S. Census Bureau, *Poverty in the United States: 1998*, P60-207 (Washington, DC: U.S. Census Bureau, 1999), Appendix B-6, Poverty Status by Age, 1959-1998.

[4] U.S. Census Bureau, *Health Insurance Coverage: 1996*, P60-100, and *Health Insurance Coverage: 1998*, P60-208 (Washington, DC: U.S. Census Bureau, 1997 and 1999).

[5] In 1996, 3.4 million low-income children were uninsured—23.3 percent of all low-income children. In 1998, 3.4 million low-income children were uninsured—25.2 percent of all low-income children. (The increase in the percentage of children without insurance is not statistically significant.)

[6] The Census Bureau warns that Medicaid coverage is under-reported in the Current Population Survey, and changes in Medicaid coverage may be affected by a downward bias. U.S. Census Bureau, *Health Insurance Coverage: 1998*.

[7] Arloc Sherman, *Extreme Child Poverty Rises Sharply in 1997* (Washington, DC: The Children's Defense Fund, August 1999). See also Wendell Primus, et al. *The Initial Impacts of Welfare Reform on the Incomes of Single-Mother Families* (Washington, DC: Center on Budget and Policy Priorities, August 1999).

[8] Pamela Loprest, *Families Who Left Welfare: Who Are They and How Are They Doing?* Assessing the New Federalism, Discussion Paper 99-02 (Washington, DC: The Urban Institute, July 1999).

[9] U.S. General Accounting Office, *Welfare Reform: Information on Former Recipients' Status*, GAO/HEHS 99-48 (Washington, DC: U.S. General Accounting Office, April 1999).

[10] Sharon Parrot, *Welfare Recipients Who Find Jobs: What Do We Know about Their Employment and Earnings?* (Washington, DC: Center on Budget and Policy Priorities, November 1998).

[11] Families USA, op. cit.

[12] Families USA, op. cit.

[13] U.S. Census Bureau, *Health Insurance Coverage: 1998*.

[14] American Academy of Pediatrics, unpublished analysis of U.S. Census Bureau, *Current Population Survey, 1994 to 1997 March Demographic File*, and *1998 State Population Projections by Single Year of Age, Sex, Race and Hispanic Origin*, Series A.

[15] Health Care Financing Administration, HCFA Form 2082, Table 31 (Ages 0-20) for Federal Fiscal Year 1996. (Hawaii data were unavailable.)

[16] The State Children's Health Insurance Program, title 21 of the Social Security Act, sec. 2101 et seq., was added by section 4901 of the Balanced Budget Act of 1997 and codified at 42 U.S.C. sec. 1397aa et seq.

[17] Net income limits must be under 200 percent of the federal poverty level, or 50 percentage points higher than the states' Medicaid income level in effect in 1997, whichever is higher. However, by using income "disregards," CHIP programs can use limits that exceed 200 percent of *gross* income but remain under 200 percent of *net* income.

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[18] Social Security Act, section 2102(c).

[19] Social Security Act, section 2101(b).

[20] Families USA, op. cit.

[21] Families USA, op. cit.

[22] U.S. General Accounting Office, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*, GAO/HEHS 98-93 (Washington, DC: U.S. General Accounting Office, March 1998).

[23] Wendy Zimmerman and Michael Fix, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County* (Washington, DC: The Urban Institute, July 1998); Michael Fix and Wendy Zimmerman, *All Under One Roof: Mixed-Status Families in an Era of Reform* (Washington, DC: The Urban Institute, June 1999).

[24] Stan Dorn and Ann M.K. Patterson, *Red Tape Epidemic: Health Coverage for Working Families at Risk* (San Francisco, CA: The Health Consumer Alliance, April 26, 1999).

[25] *Grant v. Kearney*, 99 Civ. 2147 (S.D.FL., filed August 3, 1999).

[26] Jane Longo, Manager, Bureau of KidCare, Illinois Department of Public Aid, interview by author, August 19, 1999.

[27] Office of the State Comptroller, *Department of Health's Management of the Child Health Plus Program*, Report 97-2-10 (Albany, NY: Office of State Comptroller, April 1998).

[28] *Reynolds v. Giuliani*, 98 Civ. 8877 (S.D.N.Y., order of January 25, 1999).

[29] Thomas M. Selden, Jessica S. Banthin, and Joel W. Cohen, "Medicaid's Problem Children: Eligible but not Enrolled," *Health Affairs* 17, no. 3 (May/June 1998): 192-200.

[30] Families USA, op. cit.

[31] Families USA, op. cit., p. 28.

[32] Andrew S. Bush, Swati Desai, and Lawrence M. Mead, *Leaving Welfare: Findings from a Survey of Former New York City Welfare Recipients*, HRA Working Paper 98-01 (New York, NY: Office of Policy and Program Analysis, Human Resources Administration, City of New York, September 1998).

[33] *Reynolds v. Giuliani*.

[34] Peter Feld, Courtney Matlock, and David R. Sandman, *Insuring the Children of New York City's Low-Income Families: Focus Group Findings on Barriers to Enrollment in Medicaid and Child Health Plus* (New York, NY: The Commonwealth Fund, December 1998).

[35] Office of the State Comptroller, *Department of Health's Management of the Child Health Plus Program*, Report 97-2-10 (Albany, NY: Office of the State Comptroller, April 1998).

[36] The Department of Health notifies health plans when a child is dually enrolled in Child Health Plus and Medicaid, and, after notice to the family, a child enrolled in Medicaid is disenrolled from Child Health Plus.

[37] Raymond Hernandez, "Inquiry Starts Into Decline in the Rolls for Medicaid," *New York Times*, June 8, 1999.

[38] Joe Kelly, Chief, Medi-Cal Policy Division, interview by author, August 19, 1999.

[39] Stan Dorn, et al., op. cit.

[40] Marilyn Ellwood and Kimball Lewis, *On and Off Medicaid: Enrollment Patterns for California and Florida in 1995*, Table 6 (Washington, DC: The Urban Institute, July 1999). The study of Medi-Cal enrollment in 1995 found that

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three months after losing the cash welfare: 47 percent of children were no longer enrolled in Medi-Cal, 20 percent were still in a temporary holding category, 12 percent were again receiving cash welfare, about 20 percent were in other Medicaid categories, and less than 1 percent had been transferred to poverty-level related children's Medicaid categories.

[41] Hawaii will expand eligibility for younger children in 2000; it plans further expansions but has not yet enacted them. Its 1115 waiver program, Hawaii Quest, covered children up to 300 percent of poverty until December 1997, when it was scaled back to cover children ages 6 to 18 up to only 100 percent of poverty.

[42] States can extend coverage beyond the 200-percent limit by using income "disregards." (See endnote 17.)

[43] Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie, *Southern Regional Initiatives to Improve Access to Benefits for Low-Income Families with Children* (Columbia, SC: Southern Institute on Children and Families, February 1998); Michael J. Perry, Evan Stark, and R. Burciaga Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children* (Menlo Park, CA: Kaiser Family Foundation, September 1998); Feld, op. cit.

[44] Shuptrine, op. cit.; Perry, op. cit.; Feld, op. cit.

[45] Selden, Banthin, and Cohen, "Medicaid's Problem Children."

[46] Susan Cypert, Outreach Coordinator, Arizona Health Care Cost Containment System, interview by author, August 4, 1999.

[47] California Managed Risk Medical Insurance Board, *Single Point of Entry Application Statistics, as of June 12, 1999*. www.mrmib.ca.gov.

[48] Jennifer Lloyd, Director of External Affairs, Florida Healthy Kids, interview by author, August 6, 1999; Florida Healthy Kids, *Applications Received by Healthy Kids, Statewide Applications and Eligibility Information*, June 1999. www.floridakidcare.org.

[49] Jana Key, Georgia Department of Medical Assistance, interview by author, August 12, 1999.

[50] Longo, interview. M-CHIP covers age 6-18 to 133 percent of poverty. S-CHIP covers 0-18 to 185 percent of poverty.

[51] Office of Medicaid, *Caseload Analysis Bulletin* (Columbus, OH: Department of Human Services, June 1999).

[52] California Managed Risk Medical Insurance Board, *Healthy Families Program Children Disenrollment Statistics, as of July 17, 1999*, Report 9. www.mrmib.ca.gov.

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Appendices

SOURCES AND METHODOLOGY

Data reported by the states to HCFA would be the best source of information about enrollment trends. However, national Medicaid enrollment data for Federal Fiscal Year 1998 (ending September 30, 1998) will not be released by HCFA until later in 1999, and new CHIP-related reporting forms (which have not yet been released by HCFA) will only cover the period since each state began its CHIP program.

In April 1999, HCFA released figures on the unduplicated number of children enrolled in CHIP at any time during Federal Fiscal Year 1998 and the first quarter of 1999. In 18 states this data came from quarterly reports filed by the states, but in 24 states data came from telephone interviews with state officials. HCFA has reported that 962,000 children were enrolled in CHIP programs through December 31, 1998.[1] The CHIP enrollment numbers shown in this report reflect current monthly enrollment, not total unduplicated enrollment at any time in five quarters, and thus differ from those reported by HCFA.

In order to obtain more recent enrollment information comparable to data for earlier periods, Families USA asked 12 states for monthly enrollment data from January 1996 to June 1999 for children and youth under the age of 21. We asked that enrollment data for the period after implementation of CHIP be broken down into figures for Medicaid, M-CHIP, and S-CHIP. We chose the 12 states with the largest number of uninsured children. We sought enrollment by age rather than by category of eligibility because we wanted to include all children regardless of category and some states did not distinguish between children and adults in reporting enrollment based on categories of eligibility such as disability. We also expected to find less variability in the way states reported data by age than by category of eligibility. Most of our data were gathered in July, and they generally reflect Medicaid enrollment through April 1999 and CHIP enrollment through June 1999.

We added June 1999 CHIP enrollment to April 1999 Medicaid enrollment. In most states, the most recent month for which we could obtain reliable Medicaid data was April 1999. (The reasons for the lag in Medicaid reporting are explained below). We chose to use June 1999 rather than April 1999 CHIP enrollment in order to allow at least six to eight months of CHIP enrollment experience in each state. We judged the

two-month difference between Medicaid and CHIP enrollment in 1999 to be unlikely to skew the results.

In Medicaid, children are enrolled in the same month they apply; however, eligibility determination may take place in a later month. Also, Medicaid provides for retroactive enrollment for up to three months before the month of application. For example, assuming a child applies in May, seeks retroactive coverage back to February, and has the application approved in July, it is only in July that the child appears as enrolled since February; an enrollment count taken in June does not yet have a record of this child. States address this "lag period" in two ways: they do not report eligibility until a "lag period" has expired (generally 3 to 5 months), and/or they take an enrollment snapshot that can provide current, albeit incomplete, information. In most states, the Medicaid data supplied to us from 1996 to 1999 included retroactive eligibility.

The source of CHIP enrollment data, even in the case of a Medicaid CHIP expansion, was usually different from the source of Medicaid data. In states with S-CHIP programs, the system used to record enrollment in S-CHIP was often entirely different from the system used for Medicaid. Also, in S-CHIP, enrollment is almost always prospective; that is, a child is enrolled at some future time following a determination of eligibility. In many states, decisions made by a cutoff date result in enrollment in the following month. Thus, the state can report complete June enrollment by the end of May. States with M-CHIP programs typically reported M-CHIP two ways: as a category of Medicaid with a lag period, but also as a snapshot. In order to obtain recent enrollment data, most states took a snapshot of M-CHIP enrollment that did not include retroactive eligibility.

Because we wanted to examine the combined effects of CHIP and Medicaid enrollment, we had to combine data from different sources. In order to obtain a number for regular Medicaid we deducted any CHIP enrollment included with the Medicaid data. We then added combined M-CHIP and S-CHIP enrollment from the most recent source available. The use of different sources always creates the possibility of discrepancies. Most of the data supplied to us from the states were extracts from data files used internally by the state agencies or specifically run at our request; they were not official reports. Thus, discrepancies may exist between the numbers shown here and in later reports of the same data.

To compare year-to-year changes from 1996 to 1999, we tried to compare enrollment in one month in a year to the same month in other years. In most states we were able to obtain monthly enrollment for all or part of the period from January 1996 to June 1999. This enabled us to be sure that the one comparison month was not unusual compared to month-to-month enrollment trends. Unfortunately, since not every state could supply us with data for the same months in 1996 and 1999, we sometimes had to compare different months. Two states, Illinois and Ohio, could not supply us with enrollment by age before July 1997. Louisiana was also unable to supply any monthly enrollment data for 1996. In these three states we imputed a 1996 monthly enrollment figure for each state by calculating the ratio of monthly to annual enrollment in 1997 and applying this ratio to the state's annual enrollment in 1996 as reported on HCFA form 2082.

In two states the 1999 Medicaid total includes some children enrolled in expansion programs. New York began enrolling children in M-CHIP in January 1999 but is still unable to report M-CHIP separately from Medicaid. When Ohio expanded Medicaid to uninsured children with family income up to 150 percent of poverty, it was also concerned about children with inadequate insurance who were not eligible for CHIP. To address this concern, it expanded Medicaid for otherwise insured children up to 150 percent of poverty, too. The non-CHIP expansion children in Ohio are included in the 1999 Medicaid total.

Arizona's Medicaid totals in 1996 and 1999 include a small number of children covered by state-only programs.

Most states reported Medicaid enrollment for persons under age 21, but California, Illinois, New Jersey, and Ohio reported data using an under-19 age break. Florida reported age breaks under 18 and under 22 until April 1999, when it changed its age breaks to under 19 and under 21. Rather than adjust April 1999 data for Florida, we used data only through March 1999; and, since most states reported under 21, we used under 22 rather than 18 in Florida. Pennsylvania reported enrollment by child code and not by age.

We also reviewed state child health plans and annual reports filed with HCFA, state web pages, other state specific reports and studies, and we interviewed CHIP and/or Medicaid officials as well as child advocates in all 12 states.

[1] The total shown here includes the District of Columbia but excludes the territories.

Table 4

Health Insurance Coverage of Children in 12 States and U. S.
Three year averages for 1995-1997 (numbers in thousands)

	ALL CHILDREN (ages 0 -18)			AT OR BELOW 200% OF POVERTY (ages 0 - 18)		
State	Total	Uninsured Number	Uninsured Percent	Total	Uninsured Number	Uninsured Percent
AZ	1 385	343	25%	746	282	37.9%
CA	9 591	1 729	18%	4 608	1 216	26.4%
FL	3 482	651	19%	1 633	440	27.0%
GA	2 107	328	16%	976	249	25.6%
IL	3 437	349	10%	1 319	221	16.8%
LA	1 210	266	22%	638	189	29.6%
NJ	2 044	316	15%	580	176	30.3%
NY	5 009	708	14%	2 268	474	20.9%
NC	1 812	296	16%	758	200	26.3%
OH	3 166	324	10%	1 169	203	17.4%
PA	3 127	262	8%	1 149	172	15.0%
TX	5 893	1 428	24%	2 934	1 034	35.3%
12 state total	42 263	7 000	17%	18 778	4 856	26%
US Totals	**74,462**	**10,915**	**15%**	**31,502**	**7,303**	**24.0%**
12-States as % of US Total	**57%**	**64%**		**60%**	**65%**	

Source: U.S. Bureau of the Census, March 1998, 1997, and 1996 Current Population Survey
(Numbers may not add up to totals due to rounding.)

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Table 5

Selected Outreach and Enrollment Reforms in 12 States

	Medicaid	S-CHIP	Asset Tests	Mail-In w/ No Face-To-Face Interview	Joint Applications	No Asset Test	Mini-Grants CBOs	Continuous Eligibility	Presumptive Eligibility–Children
Alaska	age 0-5 (12 mo.) age 6-18 (6 mo) eff. 1/99								
California									
Florida									
Illinois									
Massachusetts									
New York									
Pennsylvania									
Texas									
Virginia									
Washington									
Wisconsin									
Wyoming									

Key:

Medicaid: child-only Medicaid including CHIP-funded expansions. Most states have different rules when parents apply for Medicaid too.

S-CHIP: CHIP funded separate state programs.

Asset Tests: a state option to look at property ownership in addition to income in determining financial eligibility for Medicaid and CHIP.

Mini-Grants to CBOs: a state option to pay grants or fees to community-based organizations like health clinics or child advocacy groups to do outreach or assist with application forms.

Continuous Eligibility: a state option to guarantee eligibility for up to 12 months regardless of changes in family income.

Presumptive Eligibility: a state option to begin health coverage immediately while an applications is being processed.

Notes

1 In the spring of 2000, New York will begin a program called "facilitated enrollment" in which face-to-face interviews can take place at participating community-based organizations. Some areas in NY are piloting joint forms; statewide use is planned for 2000. Presumptive eligibility in Medicaid is scheduled to take effect only after half the people on Medicaid are enrolled in managed care.

2 In February 1999, Pennsylvania adopted a policy called "any forms a good form" to make Medicaid and S-CHIP application forms interchangeable.

3 The S-CHIP program in Texas will take effect in May 2000.

4 Face-to-face interviews are required with Medicaid-only application forms, but not the Presidential joint form.

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CREDITS

This report was written by:

Victoria Pulos, Assistant Director of Health Policy, Families USA

With assistance from:

Peggy Denker, Director of Publications, Families USA

The following Families USA staff contributed to the preparation of this report:

Ron Pollack, Executive Director

Rachel Klein, Health Policy Analyst

Nancy Magill, Production Assistant

Lana Lee, Intern

Patty Myung, Intern

Joseph Choi, Intern

Cover Design by:

Gallagher Wood Design

Cover Illustration by:

John M. Yanson

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